Fort Lauderdale / Broward County EMA
Broward County HIV Health Services Planning Council
An Advisory Board of the Broward County Board of County Commissioners
200 Oakwood Lane, Suite 100, Hollywood, FL, 33020 - Tel: 954-561-9681 / Fax: 954-561-9685

MEETING AGENDA

Committee: Broward County HIV Health Services Planning Council
Date/Time: September 24, 2020, 9:30 a.m. **Location:** WebEx Meeting Room
Chair: Dr. Réguel Lopes, AP **Vice-Chair:** Claudette Grant

Reminder: *Meeting Attendance Confirmation Required at least 48 Hours Prior to Meeting Date*

HIVPC Purpose: To provide planning, to promote development of HIV/AIDS health services, personnel, and facilities which meet identified health needs in a cost-effective manner, to reduce inefficiencies, and to develop HIV-related health plans.

1. CALL TO ORDER (10 minutes)

2. WELCOME AND PUBLIC RECORD REQUIREMENTS

a. Welcome and Introductions
b. Review Meeting Ground Rules, Public Comment and Public Record Requirements
c. Council Member and Guest Introductions
d. Moment of Silence
e. Excused Absences and Appointment of Alternates
f. Approval of 09/24/20 Meeting Agenda
g. Approval of 07/23/20 Meeting Minutes

3. PUBLIC COMMENT (Up to 10 minutes)

4. FEDERAL LEGISLATIVE REPORT – Handout A (Kareem Murphy)

5. CONSENT ITEMS

I. Motion to approve the Food Services Service Delivery Model (Handout B)
Justification: The model has been reviewed and approved by the Quality Management Committee.
PROPOSED BY: QMC Committee

II. Motion to approve the Mental Health Service Delivery Model (Handout C)
Justification: The model has been reviewed and approved by the Quality Management Committee.
PROPOSED BY: QMC Committee

III. Motion to approve the Non-Medical Case Management Service Delivery Model (Handout D)
Justification: The model has been reviewed and approved by the Quality Management Committee.
PROPOSED BY: QMC Committee

IV. Motion to approve the Substance Abuse - Outpatient Service Delivery Model (Handout E)
Justification: The model has been reviewed and approved by the Quality Management Committee.
PROPOSED BY: QMC Committee

6. DISCUSSION ITEMS

None.

7. NEW BUSINESS

I. Clinical Quality Management Program Update (Handout F)
Justification: To receive an update on the work of the Clinical Quality Management program and its impact on the Ryan White Part A care continuum.

II. HIVPC Membership (Handout G)

Justification: To discuss the current state of HIVPC membership.

III. Youth & Young Adult Presentation (Handout H)
Justification: To learn strategies for engaging younger unaffiliated consumers.

IV. Planning Body Collaboration (Handout I)
Justification: To discuss the outcomes and next steps from the BCHPPC, HIVPC, and SFAN leadership meeting.

8. COMMITTEE REPORTS (15 minutes)

I. COMMUNITY EMPOWERMENT COMMITTEE (CEC)

No September Meeting Held – No Quorum *Chair: Vacant, V. Chair: A. Ruffner*

II. MEMBERSHIP/COUNCIL DEVELOPMENT COMMITTEE

September 10, 2020 *Chair: V. Foster; V. Chair: T. Moragne*

A. Discussion Item:

B. Work Plan Item Update/Status Summary:

Review HIVPC Demographics: The total percentage of unaffiliated consumers for the Planning Council is below the HRSA-mandated 33%. HRSA has completed its annual evaluation of the Fort Lauderdale/Broward EMA's Part A office and has emphasized increasing unaffiliated consumer membership on the Planning Council, filling vacant Planning Council seats, and ensuring that the age of membership is reflective of the epidemic in Broward County. Currently, the Council skews older and does not represent Broward County's epidemic. The Planning Council is overrepresented by 20% for ages 60 and above, and consumer membership is at 44% overrepresentation in that age category.

Members discussed challenges with engaging community members in a virtual age and the immediate need to address the concerns outlined by HRSA. A representative with John Snow Inc. (JSI), which provides training and technical assistance to HRSA's Ryan White HIV/AIDS Programs, announced that their team would be working with PCS staff on recruitment techniques and strategies to address immediate concerns as well as focus on retention efforts.

Planning Council and Committee Attendance: There have been no warnings, no removals, and one resignation since the last MCDC meeting. Given the nature of virtual meetings and taking into consideration things that may have come up due to the pandemic, members that have had absences in the past few months will be given an excused absence for any missed meeting.

Current Applicants, Interested Parties, and Appointments: No HIVPC applications were submitted.

HIVPC Training & Presentation Plan: Since the Committee's last meeting, a Robert's Rules of Order training was conducted for all Planning Council members. The PCS staff is coordinating a Broward County's Homeless System training for all members. The Committee discussed completing additional trainings to include the topics of State-Wide Update on the Status of HIV and Drug Use & Substance Abuse. After much discussion, members agreed to have the State-Wide Update on the Status of HIV in December.

Recruitment & Retention Tool: A Committee member presented a Detroit-specific tool through Planning CHATT that examined recruitment techniques that utilized newspaper ads, community outreach, word of mouth, and online applications. The tool also emphasized the importance of conducting trainings, which ensure that members feel part of the process and that their voices are heard.

Stop, Start, and Continue Exercise: The Committee reviewed the MCDC Recruitment & Retention Plan to discuss which activities to stop, start, and continue to bolster recruitment.

C. Data Requests:
None.

D. Rationale for Recommendations:
None.

E. Data Reports/ Data Review Updates:
None.

F. Other Business Items:
None.

G. Agenda Items for Next Meeting:
Develop HIVPC Recruitment Video Script

H. Next Meeting Date:
October 6, 2020 at 3:00 p.m. (Joint meeting with CEC) Room: TBD

III. QUALITY MANAGEMENT COMMITTEE (QMC)

September 21, 2020 *Chair: Vacant, V. Chair: B. Fortune-Evans*

A. Discussion Item:

B. Work Plan Item Update/Status Summary:

Service Delivery Model Review – Non-Medical Case Management: The CQM Support Staff provided a brief overview of the proposed changes to the Non-Medical Case Management Service Delivery Model (SDM). Attendees discussed the impact of the changes. The Committee approved the new SDM.

Service Delivery Model Review – Food Services: The CQM Support Staff provided a brief overview of the proposed changes to the Food Services Service Delivery Model. Attendees discussed the impact of the changes. The Committee approved the new SDM.

Service Delivery Model Review – Mental Health: The CQM Support Staff provided a brief overview of the proposed changes to the Mental Health Service Delivery Model. Attendees discussed the impact of the changes. The Committee approved the new SDM.

Service Delivery Model Review – Substance Abuse: The CQM Support Staff provided a brief overview of the proposed changes to the Substance Abuse Service Delivery Model. Attendees discussed the impact of the changes. The Committee approved the new SDM.

HIV/AIDS Bureau (HAB) Performance Measure Review: The CQM Support Staff presented quarterly HAB performance data for FY18-20. The Support staff detailed next steps in terms of increasing data quality of HAB measures and future integrations with PE.

Network and Agency QIP Update: The CQM Support staff reviewed the quality management activities and projects that have been undertaken by agencies and Networks over the last quarter.

C. Data Requests:
None.

D. Rationale for Recommendations:
None.

E. Data Reports/ Data Review Updates:
None.

F. Other Business Items:
None.

G. Agenda Items for Next Meeting:
- *Review of Service Delivery Models*

H. Next Meeting Date:

October 19, 2020 at 12:30 p.m. Location: TBD

IV. EXECUTIVE COMMITTEE

September 17, 2020 *Chair: R. Lopes, V. Chair: C. Grant*

A. Discussion Item:

B. Work Plan Item Update/Status Summary:

HIVPC Agenda: The Executive Committee voted to approve the HIVPC agenda.

HIVPC Calendar: The Committee reviewed the October HIV Planning Council calendar.

HIVPC Demographics: The Committee reviewed the Council's demographic representation (Handout C on file). Broward's HIVPC has fallen short of the required consumer membership in recent years and HRSA has noted these shortcomings in its findings. Members discussed options for how to reach out to potential new members.

Executive Bodies Meeting: The Committee discussed the meeting of BCHPPC, HIVPC, and SFAN leadership. The meeting began with a discussion of the letter brought to the planning bodies in February (Handout D on file). Members discussed which of the outlined actions could be undertaken by the HIVPC and which may be more difficult to implement due to County and HRSA restrictions.

C. Data Requests:

The HIVPC Chair has requested information regarding Broward County ordinances and HRSA requirements as they pertain to membership restrictions.

D. Rationale for Recommendations:

None.

E. Data Reports/ Data Review Updates:

None.

F. Other Business Items:

None.

G. Agenda Items for Next Meeting:

None.

H. Next Meeting Date:

October 15, 2020 at 11:30 a.m. Location: TBD

V. PRIORITY SETTING & RESOURCE ALLOCATION COMMITTEE (PSRA)

No September Meeting Held - Canceled Chair: L. Robertson, V. Chair: Vacant

VI. SYSTEM OF CARE (SOC)

September 10, 2020 *Chair: A. Ruffner, V. Chair: J. Rodriguez*

A. Discussion Item:

B. Work Plan Item Update/Status Summary:

System of Care Presentation: A PCS Health Planner provided an overview of the responsibilities of the Committee as well as past activities. The Committee requested more information on the previously completed Black Women's study.

System of Care Policies & Procedures: The Committee reviewed its Policies & Procedures in preparation for work plan revision.

System of Care FY2020 Work Plan: SOC reviewed a draft work plan for the current fiscal year. The Committee discussed how best it could use its time in the remainder of FY2020. Members discussed reducing the number of activities on the work plan as well as their visions for the Committee. After much discussion, the SOC Work Plan will be revised and presented to the Committee at its October meeting.

C. Data Requests:

Members requested Needs Assessments completed by Ryan White Part A, hospital systems, and Ending the HIV Epidemic stakeholders.

D. Rationale for Recommendations:
None.

E. Data Reports/ Data Review Updates:
None.

F. Other Business Items:
None.

G. Agenda Items for Next Meeting:

- *Needs Assessment Presentations*
- *Who's at the Table? Exercise*
- *Collaborative Committee Event*

H. Next Meeting Date:
October 1, 2020 at 9:30 a.m. Location: TBD

**** For a detailed discussion on any of the above items, please refer to the meeting minutes. ****
Meeting Packets are available at: The HIV Planning Council Website

9. RECIPIENT REPORTS (20 minutes)

a. Part A
b. Part B (Handout J)
c. Part C
d. Part D
e. Part F
f. HOPWA
g. Prevention – Quarterly Update (January, April, July, October)

10. UNFINISHED BUSINESS

11. PUBLIC COMMENT (Up to 10 minutes)

12. ANNOUNCEMENTS

13. REQUEST FOR DATA

14. AGENDA ITEMS FOR NEXT MEETING: October 22, 2020 at 9:30 a.m. LOCATION: TBD

15. ADJOURNMENT

PLEASE COMPLETE YOUR MEETING EVALUATIONS
THREE GUIDING PRINCIPLES OF THE BROWARD COUNTY HIV HEALTH SERVICES PLANNING COUNCIL
• Linkage to Care • Retention in Care • Viral Load Suppression •

CY2020 HIVPC Attendance

Consumer	PLWHA	Absences	Count	Meeting Month	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Attendance Letters
				Meeting Date	23	27	C	C	28	25	23	C	24				
0	0	0	**1**	Arencibia, Y.	X	X			X	X	X						
0	1	0	**2**	Barnes, B.	X	X			X	X	X						
1	1	0	**3**	Bhrangger, R.	E	X			X	X	X						
1	1	0	**4**	Biggs, V.	N - 6/19					X	X						
0	0	1	**5**	Cutright, A.	X	A			X	X	X						
1	1	0		Dennis, B.	X	X			X	X	Z - 7/13						
0	0	0	**6**	Fortune-Evans, B.	X	X			X	X	X						
0	0	0	**7**	Foster, V.	X	X			X	X	X						
0	0	0	**8**	Grant, C.	X	X			X	X	X						
0	0	0		Hayes, M.	X	X			Z - 5/28								
0	0	**4**		Holness, Dale V.C. (Mayor)	N - 02/11	A			A	A	A						
1	1	0	**9**	Katz, H.B.	X	X			X	X	X						
1	1	0	**10**	Lewis, V.	X	X			X	X	X						
0	0	0	**11**	Lopes, R. *Chair*	X	X			X	X	X						
1	1	0	**12**	Marcoviche, W.	E	X			X	X	X						
0	0	**3**	**13**	Moragne, T.	A	X			A	X	A						
0	0	1	**14**	Moreno, V.	X	A			E	E	X						
0	1	0	**15**	Robertson, L.	X	X			X	X	X						
0	0	0	**16**	Rodriguez, J.	E	X			X	X	X						
0	0	0	**17**	Ruffner, A.	X	X			X	X	X						
0	0	0	**18**	Schweizer, M.	X	X			X	X	X						
1	1	0	**19**	Shamer, D.	N - 6/19					X	X						
0	0	1		Sharief, B. (Comm)	A	Z - 2/11											
0	0	1	**20**	Siclari, R.	A	X			X	X	X						
0	0	0	**21**	Wilson, I.	N - 6/19					X	X						
				Quorum = 12	15	18	0	0	17	21	20	0	0	0	0	0	

Legend:

X - present	**N - newly appointed**
A - absent	**Z - resigned**
E - excused	**C - canceled**
NQA - no quorum absent	**W - warning letter**
NQX - no quorum present	**R - removal letter**
CX - canceled due to quorum	

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MEETING MINUTES

Committee: Broward County HIV Health Services Planning Council
Date/Time: July 23, 2020, 9:30 a.m. **Location:** WebEx Meeting Room
Chair: Dr. Réquel Lopes, AP **Vice Chair:** Claudette Grant

ATTENDANCE

#	Member	Present	Absent	Recipient Staff
1	Arencibia, Y.	X		Gonzalez-Charlot, J.
2	Barnes, B.	X		Cius, W.
3	Bhrangger, R.	X		Scott, S.
4	Biggs, V.	X		Giglioli, K.
5	Cutright, A.	X		Thompson, T.
6	Fortune-Evans, B.	X		Garcia, E.
7	Foster, V.	X		
8	Grant, C.	X		**HIVPC Staff**
	Holness, Comm. D.V.C		A	Guice, M.
9	Katz, H. B.	X		Martinez, G.
10	Lewis, V.	X		Oratien, V.
11	Lopes, R. *Chair*	X		Ukpai, F.
12	Marcoviche, W.	X		Seitchick, J.
13	Moragne, T.		A	
14	Moreno, V.	X		**Guests**
15	Robertson, L.	X		Hidalgo, J.
16	Rodriguez, J.	X		Murphy, K.
17	Ruffner, A.	X		McShee, S.
18	Schweizer, M.	X		Rodriguez, A.
19	Shamer, D.	X		Murdaugh, T.
20	Siclari, R.	X		
21	Wilson, I.	X		
	Quorum = 12	**20**		

1. CALL TO ORDER

The chair called the meeting to order at 9:35 a.m.

2. WELCOME AND PUBLIC RECORD REQUIREMENTS

The HIVPC Chair welcomed everyone. Introductions were made via roll call by HIVPC members, PCS and Recipient Staff. Guests and those not previously able to state their presence were able to write-in using the chat function or speak their names into the record. Attendees were notified of Government in the Sunshine Law and meeting reporting requirements, which includes the recording of minutes. In addition, it was stated that the acknowledgment of HIV status is not required but is subject to public record if it is disclosed. A moment of silence was observed. The following motions were made:

Motion #1: To approve today's meeting agenda
Proposed by: Robertson, L. **Seconded by:** Arencibia, Y.
Action: Passed Unanimously

Motion #2: To approve the 06/25/20 minutes
Proposed by: Robertson, L. **Seconded by:** Foster, V.
Action: Passed Unanimously

3. PUBLIC COMMENT (Up to 10 minutes)

None.

4. FEDERAL LEGISLATIVE REPORT – Handout A (Kareem Murphy)

A written legislative report (Handout A on file) was provided to the Council by Kareem Murphy. Mr. Murphy noted the House has finally advanced a series of Fiscal Year (FY) 2021 appropriations bills that would fund the HIV/AIDS services continuum. The House proposes an overall $14 million increase across all program areas, for a total of $1.288 billion in which Part A would be level-funded ($655.9 million). The Minority AIDS Initiative would also receive a $3 million increase to $57 million. The Senate has not yet announced a schedule for a markup of its appropriations bills that fund the continuum.

5. CONSENT ITEMS

Motion #3: To approve the consent items
Proposed by: Fortune-Evan, B. **Seconded by:** Arencibia, Y.
Action: Passed with 1 Opposed

6. DISCUSSION ITEMS

I. Resource Allocations

The HIVPC reviewed and approved the Core and Support Services allocations that were completed by the PSRA.

Motion #4: To allocate $5,436,528 to Outpatient Ambulatory Healthcare Services for FY 2021-2022.
Proposed by: PSRA **Seconded by:** Barnes, B.
Action: Passed Unanimously

Motion #5: To allocate $481,126 to AIDS Pharmaceutical Assistance (LPAP) for FY 2021-2022.
Proposed by: PSRA **Seconded by:** Lopes, R.
Action: Passed Unanimously

Motion #6: To allocate $2,736,489 to Oral Health Care for FY 2021-2022.
Proposed by: PSRA **Seconded by:** Lopes, L.
Action: Passed Unanimously

Motion #7: To allocate $739,641 to Health Insurance Continuation Program for FY 2021-2022.
Proposed by: PSRA **Seconded by:** Grant, C.
Action: Passed Unanimously

Motion #8: To allocate $410,023 to Medical Case Management – Treatment Adherence for FY 2021-2022.
Proposed by: PSRA **Seconded by:** Katz, H. B.
Action: Passed Unanimously

Motion #9: To allocate $1,198,830 to Medical Case Management – Case Management for FY 2021-2022.
Proposed by: PSRA **Seconded by:** Lopes, R.
Action: Passed Unanimously

Motion #10: To allocate $182,052 to Mental Health for FY 2021-2022.
Proposed by: PSRA **Seconded by:** Katz, H B.
Action: Passed Unanimously

Motion #11: To allocate $285,030 to Substance Abuse – Outpatient Care for FY 2021-2022.
Proposed by: PSRA **Seconded by:** Cutright, A.
Action: Passed Unanimously

Motion #12: To allocate $582,689 to Non-Medical Case Management – Centralized Intake & Eligibility Determination (CIED) for FY 2021-2022.
Proposed by: PSRA **Seconded by:** Grant, C.
Action: Passed Unanimously

Motion #13: To allocate $121,979 to Emergency Financial Assistance for FY 2021-2022.
Proposed by: PSRA **Seconded by:** Cutright, A.
Action: Passed Unanimously

Motion #14: To allocate $839,479 to Food Bank/Food Voucher for FY 2021-2022.
Proposed by: PSRA **Seconded by:** Arencibia, Y.
Action: Passed with 1 Abstention

Motion #15: To allocate $129,151 to Legal Services for FY 2021-2022.
Proposed by: PSRA **Seconded by:** Arencibia, Y.
Action: Passed Unanimously

Motion #16: To allocate $293,826 to MAI Outpatient Ambulatory Healthcare Services for FY 2021-2022.
Proposed by: PSRA **Seconded by:** Arencibia, Y.
Action: Passed Unanimously

Motion #17: To allocate $45,792 to MAI Medical Case Management – Case Management for FY 2021-2022.
Proposed by: PSRA **Seconded by:** Fortune-Evans, B.
Action: Passed Unanimously

Motion #18: To allocate $39,276 to MAI Mental Health for FY 2021-2022.
Proposed by: PSRA **Seconded by:** Lopes, R.
Action: Passed Unanimously

Motion #19: To allocate $400,000 to MAI Substance Abuse – Outpatient for FY 2021-2022.
Proposed by: PSRA **Seconded by:** Foster, V.
Action: Passed Unanimously

Motion #20: To allocate $290,957 to MAI Non-Medical Case Management – CIED for FY 2021-2022.
Proposed by: PSRA **Seconded by:** Lopes, R.
Action: Passed with 3 Opposed

7. NEW BUSINESS

I. Discussion of HIV Planning Council & Committee Membership and Protocols

The HIVPC Manager reviewed the application process for new members of the HIVPC. Any individual solely interested in joining a Sub-Committee must complete a Committee application

and be approved by the Chair of that Committee. However, if the individual is interested in joining the full Planning Council, a Planning Council application is required, and approval to join Sub-Committees is given once the Board of County Commissioners approves the application. It is then voted on at the following HIV Planning Council meeting.

II. Discussion of Ending the HIV Epidemic & the HIV Planning Council

At the February HIVPC meeting, a guest proposed a reunion of the Planning Council and South Florida AIDS Network (SFAN). The two bodies previously operated as joint Committees. The bodies have different tasks and responsibilities, which was part of the decision to split the bodies. The split also occurred due to leadership dynamics and a lack of SFAN participation. There are also differences in operative guidelines that would have to be considered if the two bodies reconnected.

At the June 18th Executive Committee meeting, members voted to hold a meeting with the Executive body of Broward County HIV Prevention Planning Council (BCHPPC) & SFAN regarding working together moving forward. This meeting would not be one in which decisions would be made, but rather a continuance of the conversation begun by the request for the reunion. A poll to determine the date and time will be sent to participants.

COMMITTEE REPORTS (15 minutes)

I. Community Empowerment Committee

June 2, 2020 *Chair: Vacant, V. Chair: A. Ruffner*

The CEC Vice Chair announced the launch of the Broward Ryan White Part A Office's *Ryan White & You: The Simple Facts* video series, which took place on Tuesday, July 21, 2020, at 7:00 p.m. The event was in partnership with the World AIDS Museum, AIDS Healthcare Foundation, and Children's Diagnostic & Treatment Center (CDTC). The event, which was hosted on the Zoom meeting platform and shared via Facebook Live, included discussions around the importance of the services provided under the Ryan White Part A Program and a Q&A session.

II. Membership/Council Development Committee

June 11, 2020 *Chair: V. Foster, V. Chair: T. Moragne*

The report stands.

III. Quality Management Committee

June 15, 2020 *Chair: Vacant, V. Chair: B. Fortune-Evans*

The report stands.

IV. Executive Committee

June 18, 2020 *Chair: R. Lopes, V. Chair: C. Grant*

The report stands.

V. Priority Setting & Resource Allocation Committee

June 18, 2020 *Chair: L. Robertson, V. Chair: Vacant*

The report stands.

VI. System of Care Committee

No June Meeting *Chair: A. Ruffner, V. Chair: J. Rodriguez*

8. RECIPIENT REPORTS

A. Part A: The Part A Recipient announced an EHE funding opportunity for Part A Sub-Recipients funded under Disease Case Management, Food Services, and Evaluation. Providers have responded favorably to the initiative.

The Part A Office also announced that Wismy Cius has joined the Recipient staff to assist with the implementation efforts of EHE.

B. Part B: The Part B Recipient provided an overview detailing the Program's allocations and expenditures through July 2020. The AIDS Drug Assistance Program (ADAP) has made provisions for August, September, and October to provide clients with three months' worth of medication. As hurricane season approaches, the ADAP program wants to ensure that clients have their medication. This will assist with the mitigation of COVID-19 by decreasing the need to visit areas at high-risk for COVID-19. Providers have the option to continue to provide a 90-day supply of medication to stable clients.

C. Part C: The Part C Program has completed and submitted its financial report. The Program was expecting to have more than 6% unexpended funding due to a vacant position; however, funding has been completely expended. The Program has resumed limited HIV testing as some staff is out due to possible COVID-19 exposure and quarantine restrictions.

D. Part D: The Part D Program announced that the CDTC is still open and meeting clients both in-person and via telehealth. The Program is operating with limited staff as some staff is out due to COVID-19 exposure and others opting to telework.

E. Part F: The Part F Recipient stated that the clinic is not currently fully operational. Only emergency care is available at this time. Nova is seeing patients for regular care but is limiting which procedures can take place due to aerosol spray concerns.

F. HOPWA: There is no representative at this time.

G. Prevention: The Part B Recipient stated that the Prevention Program is encouraging individuals in the community to obtain at-home HIV testing using Ora-Sure. The at-home kits will be sent out with condoms and other pertinent information about resources and PrEP.

9. UNFINISHED BUSINESS

None.

10. PUBLIC COMMENT (Up to 10 minutes)

None.

11. ANNOUNCEMENTS

World AIDS Museum is hosting a discussion via Facebook Live around the documentary *Deep South*, which details HIV in the southern states.

12. REQUEST FOR DATA

None.

13. AGENDA ITEMS FOR NEXT MEETING: TBD LOCATION: TBD

14. ADJOURNMENT 11:34 a.m.

PLEASE COMPLETE YOUR MEETING EVALUATIONS

THREE GUIDING PRINCIPLES OF THE BROWARD COUNTY HIV HEALTH SERVICES PLANNING COUNCIL

• Linkage to Care • Retention in Care • Viral Load Suppression •

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HIV Planning Council Attendance CY2020

Consumer	PLWHA	Absences	Count	Meeting Month	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Attendance Letters
				Meeting Date	23	27	C	C	28	25	23						
0	0	0	1	Arencibia, Y.	X	X			X	X	X						
0	1	0	2	Barnes, B.	X	X			X	X	X						
1	1	0	3	Bhrangger, R.	E	X			X	X	X						
1	1	0	4	Biggs, V.	N – 5/28					X	X						
0	0	1	5	Cutright, A.	X	A			X	X	X						
1	1	0		Dennis, B.	X	X			X	X	Z – 7/13						
0	0	0	6	Fortune-Evans, B.	X	X			X	X	X						
0	0	0	7	Foster, V.	X	X			X	X	X						
0	0	0	8	Grant, C.	X	X			X	X	X						
0	0	0		Hayes, M.	X	X			Z – 5/21								
0	0	4		Holness, Dale V.C. (Mayor)	N - 02/11	A			A	A	A						
1	1	0	9	Katz, H.B.	X	X			X	X	X						
1	1	0	10	Lewis, V.	X	X			X	A	X						
0	0	0	11	Lopes, R. *Chair*	X	X			X	X	X						
1	1	0	12	Marcoviche, W.	E	X			X	X	X						
0	0	3	13	Moragne, T.	A	X			A	X	A						
0	0	2	14	Moreno, V.	X	A			A	E	X						
0	1	0	15	Robertson, L.	X	X			X	X	X						
0	0	0	16	Rodriguez, J.	E	X			X	X	X						
0	0	0	17	Ruffner, A.	X	X			X	X	X						
0	0	0	18	Schweizer, M.	X	X			X	X	X						
1	1	0	19	Shamer, D.	N- 5/28					X	X						
0	0	1		Sharief, B. (Comm)	A	Z - 02/11											
0	0	1	20	Siclari, R.	A	X			X	X	X						
0	0	0	21	Wilson, I.	N – 5/28					X	X						
				Quorum = 11	15	18	0	0	17	17	20	0	0	0	0	0	

Legend:

X - present	**N - newly appointed**
A - absent	**Z - resigned**
E - excused	**C - canceled**
NQA- no quorum absent	**W - warning letter**
NQX - no quorum present	**R - removal letter**
CX - canceled due to quorum	

HANDOUT A

Update for Broward County
HIV Health Services Planning Council

From: Kareem Murphy
Date: September 21, 2020

Federal Funding Update

Appropriations
Consideration of the annual appropriations bills stalled before the House and Senate took their respective August District Work Periods (recess). The House did approve a series of Fiscal Year (FY) 2021 appropriations bills that would fund the HIV/AIDS services continuum. The House proposed an overall $14 million increase across all program areas, for a total of $1.288 billion. Part A would be level funded ($655.9 million) but they would also increase the President's Ending the Epidemic Plan by $25 million. All other Ryan White titles would receive level funding. The Minority AIDS Initiative would receive a small $3 million increase to $57 million. HOPWA, which is funded through another appropriations bill for the U.S. Department of Housing and Urban Development, would receive a $20 increase to $430 million. The Senate has not marked up of its appropriations bills that fund the continuum.

Congress must pass a stop-gap temporary spending bill to avoid a government shut down by the end of September. The chambers are currently at an impasse over the contents of such a bill, with the Senate rejecting the House's latest offer. What appears to not be contentious is the extension date (December 11). Given the dynamics of the Presidential race and the competitiveness over control of the Senate, it is possible final funding would not be determined until mid- to late December.

COVID Response
The House passed the HEROES Act back in May. It would provide $10 million for Ryan White programs through the end of FY 2022. Allocations within the title would be at the discretion of the Department of Health and Human Services. It also includes $15 million for HOPWA, $11.1 billion for SNAP (the Supplemental Nutrition Assistance Program), and $100 billion for emergency rental assistance. Senate packages have not included funding for the continuum.

BROWARD COUNTY RYAN WHITE PART A PROGRAM

Food Services Service Delivery Model

BROWARD COUNTY FLORIDA
Health Care Services
Ryan White Part A Program

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I. Service Definitions

HRSA Definition[1]

Food bank/home delivered meals refers to the provision of actual food items, hot meals, or a voucher program to purchase food. This also includes the provision of essential non-food items that are limited to the following:

- Personal hygiene products
- Household cleaning supplies
- Water filtration/purification systems in communities where issues of water safety exist

Local Definition

Food Services are provided to clients requiring supplemental nutrition. Food Services must be provided in consultation with a nutritionist or other health professional and must include a nutritional assessment and plan. The plan identifies dietary factors that impact client health and is individualized and tailored to each client's needs. Food Services provide a nutritious and well-balanced food supplement to a client's nutritional intake and offer the client choice in selecting menu options that support health needs (e.g. nutritional deficiencies, metabolic conditions).

The provision of food services may be in the form of food bank or food vouchers. **Food Bank** services are provided at a central distribution center that warehouses and provides nutritious groceries for clients. **Food Voucher** services are provided in the form of a certificate/gift card for a grocery store, allowing clients to purchase nutritious food. Clients receiving food vouchers must be able to shop for and prepare their meals. Alcohol and tobacco products cannot be purchased with food vouchers.

II. Key Service Components and Activities

In addition to the Food Services Service Delivery Model (SDM), all providers must adhere to the minimum requirements set forth in the Broward County Ryan White Part A Universal SDM. Providers must also adhere to standards and requirements set forth in the Broward County, Human Services Department, Community Partnerships Division Provider Handbook for Contracted Services Providers, individual contracts, and applicable contract adjustments. Providers must refer to their individual contract for service-specific client eligibility requirements. Providers of Food Services are expected to comply with applicable State and/or Federal standards and guidelines relevant to services delivered within this service category, including state and local health codes. Additionally, providers must provide services in accordance with the USDA Dietary Guidelines and standards of Dietitians in AIDS Care and the American Dietetic Association.

Provision of Food Bank Services

Providers of Food Bank services must maintain a list of available foods for clients to select their weekly food provisions and document the foods selected by the client at each distribution. Menu and food choice development must occur under the direction of a Registered Dietician to ensure food packages contain a variety of nutritious foods, align with the nutritional needs of the client, and are culturally/ethnically appropriate, when possible. Providers must ensure that the client's

[1] *Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Uses of Funds Policy Clarification Notice (PCN) #16-02*. Health Resources and Services Administration (HRSA)/ HIV/AIDS Bureau (HAB). [Online] October 22, 2018. https://hab.hrsa.gov/sites/default/files/hab/program-grants-management/ServiceCategoryPCN_16-02Final.pdf.

food selections are in the food pick-up/delivery package. Clients must confirm receipt of all food distributions as evidenced by the client signature and date of pick up.

Provision of Food Voucher Services

Providers of Food Voucher services must develop and implement policies and procedures for receiving, distributing, and tracking the food voucher inventory. Policies and procedures must ensure that no prohibited items are purchased, purchases support the client's nutritional needs, and no cash is exchanged between the vendor and the client. Food vouchers must clearly state that the use of food vouchers to purchase alcohol, tobacco, lottery, and non-food products is prohibited. Providers must document client acceptance and understanding of the Food Voucher Policy, as evidenced by client signature, in the designated HIV Management Information System (MIS).

Food vouchers must be tracked using a voucher identification number. Clients must return receipts showing purchases made with the numbered food voucher distributed to them. Providers must confirm the purchases made meet food voucher guidelines before another voucher is issued. The provider must implement a corrective action for clients who purchase ineligible items. Corrective actions may include warnings and suspension from the Food Voucher Program. Providers must document food vouchers distributed to each client by identification number and returned receipts in the designated HIV MIS.

III. Broward Outcomes and Indicators

Table 1. Outcomes, Indicators, and Measure

Outcomes	Indicators	Measure
1. Increased access, retention, and adherence to primary medical care.	1.1. 85% of clients are retained in primary medical care.	1.1.1. Client appointment record in designated HIV MIS.
2. Increased viral suppression.	2.1. 80% of clients on ART for more than six months will have a viral load less than 200 copies/mL.	2.1.1. Client viral load test result in designated HIV MIS. 2.1.2. Client prescription of ART documented in designated HIV MIS.

IV. Assessment

Nutritional Assessment

Clients receiving Food Services must complete a nutritional assessment within 60 days of initial encounter with the provider, and annually thereafter. The nutritional assessment must be completed by or under the supervision of a Registered Dietitian, be signed by the provider and client, and documented in the designated HIV MIS. The nutritional assessment must include, at minimum:

- Type of food or meal services being requested, i.e., grocery/pantry bags or food vouchers
- Medical issues that require a therapeutic or modified diet due to diabetes, renal (kidney) disease, high blood pressure, food allergies or intolerances, metabolic complications, and other medical conditions that impacts nutritional need
- Current weight and history of significant weight loss or gain in the past six months

- List of current medications (HIV-related and other, including vitamins and minerals, and herbal and complementary/alternative therapies)
- Daily physical activity level
- Interest in or need for nutritional education
- Access to adequate and safe food storage and meal preparation

V. Standards for Service Delivery

Table 2. Food Services Standards for Service Delivery

Standard	Measure
1. Clients complete a nutritional assessment, by or under the supervision of a Registered Dietitian, within 60 days of initial encounter, and annually thereafter.	1.1. Nutritional assessment signed and dated by the provider and client in the designated HIV MIS.
2. Foods selected by clients align with the needs identified in the nutritional assessment and are culturally/ethnically appropriate, when possible.	2.1. Receipt of food distribution with client signature and date in the designated HIV MIS. 2.2. Nutritional assessment signed and dated by the provider and client in the designated HIV MIS.
3. Clients confirm receipt of all food distributions as evidenced by the client signature and date of pick up.	3.1. Receipt of food distribution with client signature and date in the designated HIV MIS.
4. Clients receive nutritional education by or under the supervision of a Registered Dietitian when needed.	4.1. Documentation of need for nutritional education and education provided in the designated HIV MIS. 4.2. Referral documented in the designated HIV MIS if the need for Medical Nutrition Therapy is identified.
5. Clients demonstrate acceptance and understanding of the Food Voucher Policy prior to receiving Food Voucher services.	5.1. Food Voucher Policy signed and dated by the client in the designated HIV MIS.
6. Clients utilize food vouchers to purchase foods that support the client's nutritional needs.	6.1. Receipt showing purchases made with the numbered food voucher in the designated HIV MIS.
7. Providers confirm purchases made with food vouchers meet set guidelines before another voucher is issued.	7.1. Receipt showing purchases made with the numbered food voucher in the designated HIV MIS.

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BROWARD COUNTY
RYAN WHITE PART A PROGRAM
Mental Health
Service Delivery Model

BROWARD COUNTY
FLORIDA
Health Care Services
Ryan White Part A Program

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I. Service Definitions

HRSA Definition[1]

Mental Health Services (MHS) are the provision of outpatient psychological and psychiatric screening, assessment, diagnosis, treatment, and counseling services offered to clients living with HIV. Services are based on a treatment plan, conducted in an outpatient group or individual session, and provided by a mental health professional licensed or authorized within the state to render such services. Such mental health professionals typically include psychiatrists, psychologists, and licensed clinical social workers.

Local Definition

MHS are psychotherapeutic services offered to individuals with a diagnosed mental illness, conducted in a group or individual setting, and provided by a mental health professional licensed or authorized within the State of Florida to render such services. These services are grounded in an understanding of and responsiveness to the impact of trauma; emphasizes physical, psychological, and emotional safety for both providers and survivors; and creates opportunities for clients to rebuild a sense of control and empowerment.

II. Key Service Components and Activities

In addition to the Mental Health Service Delivery Model (SDM), all providers must adhere to the minimum requirements set forth in the Broward County Ryan White Part A Universal SDM. Providers are subject to Florida's Statute Title XXIX, Chapter 394[2]. Per Florida Law, professional staff providing treatment, counseling, or support group facilitation must be a licensed professional or supervised by a licensed professional. Providers must also adhere to standards and requirements set forth in the Broward County, Human Services Department, Community Partnerships Division Provider Handbook for Contracted Services Providers, Florida Medicaid Community Behavioral Health Services Coverage and Limitations Handbook,[3] individual contracts, and applicable contract adjustments. Providers must refer to their individual contract for service-specific client eligibility requirements. Providers of MHS are expected to comply with applicable State and/or Federal standards and guidelines relevant to services delivered within this service category.

Trauma-Informed Approach to Service Delivery

MHS must be rendered with a trauma-informed approach, acknowledging that traumas may have occurred or be active in clients' lives and can manifest physically, mentally, and/or behaviorally. Trauma-informed services are grounded in an understanding of and responsiveness to the impact of trauma; emphasizes physical, psychological, and emotional safety for both providers and survivors; and creates opportunities for clients to rebuild a sense of control and empowerment. Providers must focus on prevention strategies that avoid re-traumatization in treatment, promote resilience, and prevent the development of trauma-related disorders.

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[1] *Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Uses of Funds Policy Clarification Notice (PCN) #16-02.* Health Resources and Services Administration (HRSA)/ HIV/AIDS Bureau (HAB). October 22, 2018. https://hab.hrsa.gov/sites/default/files/hab/program-grants-management/ServiceCategoryPCN_16-02Final.pdf.

[2] FLA. STAT. § 394.

[3] Agency for Health Care Administration. *Florida Medicaid Community Behavioral Health Services Coverage and Limitations Handbook.* 2014.

III. Broward Outcomes and Indicators

Table 1. Outcomes, Indicators, and Measure

Outcomes	Indicators	Measure
1. Improvement in client's symptoms and/or behaviors associated with primary mental health diagnosis.	1.1. 85% of clients achieve treatment plan goals by designated target date.	1.1.1. Treatment plan documented in the designated HIV Management Information System (MIS).
2. Increased access, retention, and adherence to primary medical care.	2.1. 85% of clients are retained in primary medical care.	2.1.1. Client appointment record in designated HIV MIS.

IV. Assessment and Treatment Plan

Assessment[3]

During the first encounter with a client, the provider must establish a provisional diagnosis and treatment plan goal. Prior to the development of a comprehensive treatment plan, providers must conduct a biopsychosocial assessment. The biopsychosocial assessment must be completed in the designated HIV MIS within three counseling sessions and reviewed and signed by a licensed professional. The biopsychosocial assessment, at minimum, must include the following:

- Presenting problems
- Primary care post-traumatic stress disorder (PC-PTSD) screening[4]
- Biological factors
- Psychological factors
- Social factors
- Summary of findings
- Diagnostic impression
- Treatment recommendations

When clinically indicated, additional assessments may be completed as indicated within the Florida Medicaid Community Behavioral Health Services Coverage and Limitations Handbook.

Treatment Plan[3]

Providers must work with each client to develop an individualized treatment plan based on the needs identified in the biopsychosocial assessment. The treatment plan must be goal-oriented with measurable objectives. The provider must assist the client to define goals and document the progress and assistance provided to the client. Treatment plans become effective on the date the plan is signed and dated by the licensed professional and the client.

Treatment plans must contain, at minimum, the following components:

[4] Health Resources and Services Administration. *Primary Care PTSD Screen for DSM-5 (PC-PTSD-5).* https://www.hrsa.gov/behavioral-health/primary-care-ptsd-screen-dsm-5-pc-ptsd-5.

- The client's diagnosis code(s) consistent with assessments
- A list of the services to be provided to client (treatment plan development and review, and evaluation/assessment services provided to establish a diagnosis; however, information gathered by the provider for the development of the treatment plan need not be listed)
- The amount, frequency, and duration of each service to be provided to the patient as part of the six-month in duration treatment plan (e.g., four units of therapeutic behavioral on-site services two days per week for six months). It is not permissible to use the terms "as needed," "p.r.n.," or to state that the client will receive a service "x to y times per week"
- Goals that are individualized, strength-based, and appropriate to the client's diagnosis, age, culture, strengths, abilities, preferences, and needs, as expressed by the client
- Measurable objectives with target completion dates identified for each goal
- Dated signature of the client or client's parent, guardian, or legal custodian (if client is under 18 years of age)
- Dated signature of licensed provider
- A signed and dated statement by the licensed professional stating services are medically necessary and appropriate to the client's diagnosis and needs
- Discharge criteria (individualized, measurable criteria that identify the client's readiness to transition to a new level of care or out of care)

Treatment Plan Review[3]

A formal review of the treatment plan must be conducted every six months, at a minimum. Treatment plans may be reviewed more than once every six months when significant changes occur. The treatment plan review requires the participation of the client and the treatment team members identified in the client's individualized treatment plan. Activities, notations of discussions, findings, conclusions, and recommendations must be documented during the treatment plan review. Any modifications or additions to the treatment plan made during the review must be documented. The treatment plan must be signed and dated by a licensed professional and the client.

The formal treatment plan review must contain, at minimum, the following components:

- Current diagnosis code(s) and justification for any changes in diagnosis
- Client progress toward meeting individualized goals and objectives
- Client progress toward meeting individualized discharge criteria
- Updates to aftercare plan
- Findings/interpretive summary
- Recommendations
- Dated signature of the client or client's parent, guardian, or legal custodian (if client is under 18 years of age)
- Dated signature of licensed professional who participated in the review of the plan
- A signed and dated statement by the licensed professional stating services are medically necessary and appropriate to the client's diagnosis and needs

V. Standards for Service Delivery

Table 2. Mental Health Standards for Service Delivery

Standard	Measure
1. Client is asked to give express and informed consent for treatment.	1.1. Signed informed consent form in the client file.
2. Provider conducts a biopsychosocial assessment with each client prior to the development of a treatment plan within three counseling sessions.	2.1. Completed biopsychosocial assessment signed by licensed professional in the designated HIV MIS.
3. Provider works with each client to develop a detailed treatment plan.	3.1. Treatment plan signed and dated by licensed professional and client in the designated HIV MIS.
4. Provider conducts a formal treatment plan review at least every six months.	4.1. Updated treatment plan with signature and date of licensed professional and client in the designated HIV MIS.
5. Assistance provided to client and progress made toward achieving treatment plan goals is documented in the client file within three business days of meeting with the client.	5.1. Documentation of client communication, services provided, and progress made towards treatment plan goals in the designated HIV MIS.
6. All client communication is documented in client file and include: a date, length of time spent with client, person(s) included in the encounter, summary of what was communicated, and provider signature.	6.1. Detailed documentation with provider signature of all client communication in the client file.
7. Progress notes in the client file are linked to a treatment plan goal.	7.1. Progress notes in the designated HIV MIS.

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BROWARD COUNTY RYAN WHITE PART A PROGRAM

Non-Medical Case Management Service Delivery Model

BROWARD COUNTY FLORIDA
Health Care Services
Ryan White Part A Program

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I. Service Definitions

HRSA Definition[1]

Non-Medical Case Management (NMCM) services are the provision of a range of client-centered activities focused on improving access to and retention in needed core medical and support services. NMCM provides coordination, guidance, and assistance in accessing medical, social, community, legal, financial, employment, vocational, and/or other needed services. NMCM services may also include assisting eligible clients to obtain access to other public and private programs for which they may be eligible, such as Medicaid, Children's Health Insurance Program, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer's Patient Assistance Programs, Department of Labor or Education-funded services, other state or local health care and supportive services, or private health care coverage plans. NMCM services includes all types of case management encounters (e.g., face-to-face, telehealth, phone contact, and any other forms of communication).

Local Definition

NMCM services support client achievement of wellness and autonomy by facilitating social service needs of clients. NMCM is a collaborative process of assessment, planning, facilitation, and evaluation of service options for addressing clients' medical and social needs including benefits/entitlement, counseling, and referral activities assisting them to access other public and private programs for which they may be eligible (e.g., Medicaid, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturers' Patient Assistance Programs, and other State or local health care and supportive services). The goals of this intervention are retention in care, sustained viral suppression, compliance with medical care and addressing any service needs.

II. Key Service Components and Activities

In addition to the NMCM Service Delivery Model (SDM), all providers must adhere to the minimum requirements set forth in the Broward County Ryan White Part A Universal SDM. Providers must also adhere to standards and requirements set forth in the Broward County, Human Services Department, Community Partnerships Division Provider Handbook for Contracted Services Providers, individual contracts, and applicable contract adjustments. Providers must refer to their individual contract for service-specific client eligibility requirements. Providers of NMCM services are expected to comply with applicable State and/or Federal standards and guidelines relevant to services delivered within this service category.

Peer Counseling

Peer counseling is a required component of NMCM services. Peer counseling services assist clients with navigating the system of care and meeting action plan goals. A Case Management supervisor must oversee all peer counseling activities. Peer counseling activities include:

- Assist clients in navigating the health care system
- Assist clients in adhering to medical appointments and treatment
- Support clients in achieving and maintaining viral suppression

[1] *Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Uses of Funds Policy Clarification Notice (PCN) #16-02*. Health Resources and Services Administration (HRSA)/ HIV/AIDS Bureau (HAB). [Online] October 22, 2018. https://hab.hrsa.gov/sites/default/files/hab/program-grants-management/ServiceCategoryPCN_16-02Final.pdf.

- Support clients in making behavioral health changes that improve their general health and quality of life
- Identification of and linkage to needed services
- Assist client in reducing barriers to meet action plan goals

III. Broward Outcomes and Indicators

Table 1. Outcomes, Indicators, and Measure

Outcomes	Indicators	Measure
1. Increased access, retention, and adherence to primary medical care.	1.1. 85% of clients achieve one or more action plan goals by the target resolution date.	1.1.1. Client action plan in designated HIV Management Information System (MIS).
	1.2. 85% of clients are retained in primary medical care.	1.2.1. Client appointment record in designated HIV MIS.

IV. Assessment and Action Plan

Assessment

Providers must conduct an assessment of the client's barriers to primary medical care, medication adherence, and service needs within three sessions of the initial visit. The assessment must be documented using the "Client Assessment" form in the designated HIV MIS and include, at minimum, the following components:

- Medical information, including overall health, laboratory results, and prescribed medication regimen
- Pregnancy information for female clients, including pregnancy history
- Additional core service needs, including, mental health, oral health, nutritional therapy
- Support service needs, including financial, support groups, legal assistance, food bank, vocational, and transportation
- Risk assessment, including knowledge of HIV and STD testing, prevention, and treatment
- Quality of life, including factors related to finances, culture, language, housing status, and need for assistance with activities of daily living
- Interpersonal violence

Reassessment

A reassessment must be conducted every six months, at a minimum. A reassessment may occur more than once every six months if significant changes occur. Reassessments require the participation of the client and provider to evaluate client health and identify changes since the last assessment to determine new or ongoing needs. Activities, notations of discussions, conclusions, and recommendations must be documented during the reassessment.

Relevant Areas of Concern

Following the completion of the assessment or reassessment, the designated HIV MIS generates a list of the clients "Relevant Areas of Concern." Providers must utilize the "Relevant Areas of Concern" list to assist the client with prioritizing areas to be addressed in the action plan.

Action Plan
Providers must work with each client to develop an action plan with goals related to the needs identified in the assessment. The action plan must be developed the same day the assessment is completed and signed and dated by the provider and client. The action plan must be individualized, culturally appropriate, and goal-oriented with measurable objectives. Providers must assist clients to develop appropriate strategies to accomplish established goals. The action plan must be documented in the designated HIV MIS and contain, at minimum, the following components:

- Date the action plan was initiated and completed
- Case Manager and Supervisor review and date
- Life areas with identified difficulties as indicated in coordination with client
- Date client entered case management
- Date of client's first medical appointment and documentation of client's retention/ engagement in medical care while receiving case management services
- Goals must contain, at minimum, the following components:
    - Goal category (access, adherence, and retention)
    - Goal statement that is SMART (specific, measurable, attainable, realistic, and time-based)
    - Specified interventions to achieve the goal statement
    - Date goals are established
    - Target date for goal completion

Providers must maintain ongoing monitoring and communication with clients to ensure linkage to and retention in needed services. Providers must document action plan progress, assistance provided, and communication with clients in the designated HIV MIS, including phone calls, mail, face-to-face, and electronic communication. Checking lab reports (trending viral load and CD4 values and sharing trends with clients) and validating medication pick-ups at the pharmacy constitute follow-up. On a monthly basis, Case Management supervisors must review a sample of open client action plans to identify opportunities for improvement. All completed action plans must be reviewed, signed, and dated by Case Management supervisors.

Action Plan Review
An action plan review must be conducted every six months, at a minimum, to assess the efficacy of the action plan. An action plan review may occur more than once every six months if significant changes occur. Any modifications or additions to the action plan made during the review must be documented. The action plan must be signed and dated by the provider and client.

V. Standards for Service Delivery

Table 2. NMCM Standards for Service Delivery

Standard	Measure
1. Provider conducts an assessment with each client within three sessions of the initial visit and at least every six months thereafter.	1.1. Completed assessment in the designated HIV MIS.
2. Provider works with each client to develop an action plan the same day the assessment is completed.	2.1. Action plan signed and dated by the provider and client in the designated HIV MIS.

Standard	Measure
3. Provider conducts an action plan review every six months, at minimum.	3.1. Action plan signed and dated by the provider and client in the designated HIV MIS.
4. Case Management supervisors review a sample of open client action plans each month to identify opportunities for improvement.	4.1. Open action plans in the designated HIV MIS. 4.2. Documentation of monthly reviews and identified opportunities for improvement.
5. Completed action plans are reviewed by Case Management supervisors.	5.1. Completed action plans signed and dated by Case Management supervisor in the designated HIV MIS.
6. Assistance provided to client and progress made toward achieving action plan goals is documented in the client file within three business days of meeting with the client.	6.1. Documentation of client communication, services provided, and progress made towards action plan goals in the designated HIV MIS.

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BROWARD COUNTY
RYAN WHITE PART A PROGRAM
Substance Abuse – Outpatient
Service Delivery Model

BROWARD COUNTY
FLORIDA
Health Care Services
Ryan White Part A Program

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I. Service Definitions

HRSA Definition[1]

Substance Abuse Outpatient Care is the provision of outpatient services for the treatment of drug or alcohol use disorders. Activities under Substance Abuse Outpatient Care include screening, assessment, diagnosis, and/or treatment of substance use disorder, including:

- Pretreatment/recovery readiness programs
- Harm reduction
- Behavioral health counseling associated with substance use disorder
- Outpatient drug-free treatment and counseling
- Medication assisted therapy
- Neuro-psychiatric pharmaceuticals
- Relapse prevention

Local Definition

Substance Abuse – Outpatient services are medical or other treatment and/or counseling services provided to clients to address substance use disorders (SUDs) (i.e. recurrent use of alcohol, opiates, stimulants, or other controlled or uncontrolled substances causing clinically significant distress or impairment in physical, social or occupational functioning). These services will be provided by appropriately credentialed and/or licensed treatment professionals. Substance Abuse – Outpatient services include psychological assessment and evaluation, drug testing, diagnosis, treatment planning with written goals, crisis counseling, periodic reassessments, outpatient day treatment, intensive day/night treatment, re-evaluations of plans and goals documenting progress, and referrals to psychiatric and/or other services as appropriate to improve adherence to treatment and improve client health outcomes.

II. Key Service Components & Activities

In addition to the Substance Abuse – Outpatient Service Delivery Model (SDM), all providers must adhere to the minimum requirements set forth in the Broward County Ryan White Part A Universal SDM. Providers are subject to Florida's Statute Title XXIX, Chapter 394[2]. Per Florida Law, professional staff providing treatment, counseling, or support group facilitation must be a licensed professional or supervised by a licensed professional. Providers must also adhere to standards and requirements set forth in the Broward County, Human Services Department, Community Partnerships Division Provider Handbook for Contracted Services Providers, Florida Medicaid Community Behavioral Health Services Coverage and Limitations Handbook [3], individual contracts, and applicable contract adjustments. Providers must refer to their individual contract for service-specific client eligibility requirements. Providers of Substance Abuse – Outpatient services are expected to comply with applicable State and/or Federal standards and guidelines relevant to services delivered within this service category.

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[1] *Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Uses of Funds Policy Clarification Notice (PCN) #16-02*. Health Resources and Services Administration (HRSA)/ HIV/AIDS Bureau (HAB). [Online] October 22, 2018. https://hab.hrsa.gov/sites/default/files/hab/program-grants-management/ServiceCategoryPCN_16-02Final.pdf.

[2] FLA. STAT. § 394.

[3] Agency for Health Care Administration. *Florida Medicaid Community Behavioral Health Services Coverage and Limitations Handbook.* 2014.

Outpatient Care
Outpatient substance abuse care treats ameliorate negative symptoms from SUDs and restores effective functioning in persons diagnosed with substance-use dependency or addiction. Outpatient care is appropriate as an initial level of care for clients with less severe disorders, in early stages of change (as a "step down" from intensive outpatient substance abuse services), or stable and ongoing monitoring or disease management. Outpatient care is provided less than nine hours weekly.

Intensive Outpatient Services
Intensive outpatient services provide essential addiction education and treatment to clients with SUDs and have gradations of intensity. Intensive outpatient services are a step down from substance abuse day treatment. At a minimum, intensive outpatient services provide a support system including medical, psychologic, psychiatric, laboratory, and toxicology services.

Day Treatment
Day treatment services are the highest intensity of treatment for substance use disorders that are directly provided in the Broward County Ryan White EMA. Day treatment is appropriate for clients who are living with unstable medical and psychiatric conditions. Day treatment, at a minimum, meets the same treatment goals as described in *Intensive Outpatient Services*, with psychiatric and other medical consultation services available more expediently and longer in duration.

III. Broward Outcomes & Indicators

Table 1. Outcomes, Indicators, and Measure

Outcomes	Indicators	Measure
1. Improvement in client's symptoms and/or behaviors associated with primary substance abuse diagnosis.	1.1. 85% of clients achieve treatment plan goals by designated target date.	1.1.1. Treatment plan documented in designated HIV Management Information System (MIS).
2. Increased access, retention, and adherence to primary medical care.	2.1. 85% of clients are retained in primary medical care.	2.1.1. Client appointment record in designated HIV MIS.

IV. Assessment and Treatment Plan

Assessment[3]
Providers will schedule first appointment for client within 3 business days of initial contact. During the first encounter with a client, the provider must establish a provisional diagnosis and treatment plan goal. Prior to the development of a comprehensive treatment plan, providers must conduct a biopsychosocial assessment. The biopsychosocial assessment must be completed in the designated HIV MIS within three counseling sessions and reviewed and signed by a licensed professional. The biopsychosocial assessment, at minimum, must include the following:

- Presenting problems

- Primary care post-traumatic stress disorder (PC-PTSD) screening[4]
- Biological factors
- Psychological factors
- Social factors
- Summary of findings
- Diagnostic impression
- Treatment recommendations

When clinically indicated, additional assessments may be completed as indicated within the Florida Medicaid Community Behavioral Health Services Coverage and Limitations Handbook.

Treatment Plan[3]

Providers must work with each client to develop an individualized treatment plan based on the needs identified in the biopsychosocial assessment. The treatment plan must be goal-oriented with measurable objectives. The provider must assist the client to define goals and document the progress and assistance provided to the client. Treatment plans become effective on the date the plan is signed and dated by the licensed professional and the client. Treatment plans must contain, at minimum, the following components:

- The client's diagnosis code(s) consistent with assessments
- A list of the services to be provided to client (treatment plan development and review, and evaluation/assessment services provided to establish a diagnosis; however, information gathered by the provider for the development of the treatment plan need not be listed)
- The amount, frequency, and duration of each service to be provided to the patient as part of the six-month in duration treatment plan (e.g., four units of therapeutic behavioral on-site services two days per week for six months). It is not permissible to use the terms "as needed," "p.r.n.," or to state that the client will receive a service "x to y times per week"
- Goals that are individualized, strength-based, and appropriate to the client's diagnosis, age, culture, strengths, abilities, preferences, and needs, as expressed by the client
- Measurable objectives with target completion dates identified for each goal
- Dated signature of the client or client's parent, guardian, or legal custodian (if client is under 18 years of age)
- Dated signature of licensed provider
- A signed and dated statement by the licensed practitioner stating services are medically necessary and appropriate to the client's diagnosis and needs
- Discharge criteria (individualized, measurable criteria that identifies the client's readiness to transition to a new level of care or out of care)

Treatment Plan Review[3]

For clients utilizing outpatient treatment for substance use disorders, a formal review of the treatment plan must be conducted every six months, at a minimum. For clients utilizing intensive outpatient services or day treatment, a formal review of the treatment plan must be conducted every three months, at a minimum.

[4] Health Resources and Services Administration. *Primary Care PTSD Screen for DSM-5 (PC-PTSD-5).* https://www.hrsa.gov/behavioral-health/primary-care-ptsd-screen-dsm-5-pc-ptsd-5.

Treatment plans may be reviewed more frequently when significant changes occur. The treatment plan review requires the participation of the client and the treatment team members identified in the client's individualized treatment plan. Activities, notations of discussions, findings, conclusions, and recommendations must be documented during the treatment plan review. Any modifications or additions to the treatment plan made during the review must be documented. The treatment plan must be signed and dated by a licensed practitioner and the client.

The formal treatment plan review must contain, at minimum, the following components:

- Current diagnosis code(s) and justification for any changes in diagnosis
- Client progress toward meeting individualized goals and objectives
- Client progress toward meeting individualized discharge criteria
- Updates to aftercare plan
- Findings/interpretive summary
- Recommendations
- Dated signature of the client or client's parent, guardian, or legal custodian (if client is under 18 years of age)
- Dated signature of licensed practitioner who participated in the review of the plan
- A signed and dated statement by the licensed practitioner stating services are medically necessary and appropriate to the client's diagnosis and needs

V. Standards for Service Delivery

Table 2. Substance Abuse – Outpatient Service Delivery Standards

Standard	Measure
1. Client is asked to give express and informed consent for treatment.	1.1. Signed informed consent form in the client file.
2. Provider conducts a biopsychosocial assessment with each client prior to the development of a treatment plan within three counseling sessions.	2.1. Completed biopsychosocial assessment signed by licensed practitioner in the designated HIV MIS.
3. Provider works with each client to develop a detailed treatment plan.	3.1. Treatment plan signed and dated by licensed practitioner and client in the designated HIV MIS.
4. Provider conducts a formal treatment plan review at least every three months (intensive outpatient treatment, or day treatment) or at least every six months (outpatient)	4.1. Updated treatment plan with signature and date of licensed practitioner and client in the designated HIV MIS.
5. Assistance provided to client and progress made toward achieving treatment plan goals is documented in the client file within three business days of meeting with the client.	5.1. Documentation of client communication, services provided, and progress made towards treatment plan goals in the designated HIV MIS.

Standard	Measure
6. All client communication is documented in client file and include: a date, length of time spent with client, person(s) included in the encounter, summary of what was communicated, and provider signature.	6.1. Detailed documentation with provider signature of all client communication in the designated HIV MIS.
7. Progress notes in the client file are linked to a treatment plan goal.	7.1. Progress notes in the designated HIV MIS.

Clinical Quality Management (CQM) Update FY2020 Q1 & Q2

Service Delivery Models (SDM)

Reviewed and Approved by HIVPC:	Under Review by QMC/HIVPC:	In Development/Revision:
Universal (7/2020) Legal Services (7/2020) Health Insurance Continuation Program-HICP (7/2020) Oral Health Services (7/2020)	Non-Medical Case Management (9/2020) Food Services (9/2020) Mental Health (9/2020) Substance Abuse- Outpatient (9/2020)	Disease Case Management-DCM Integrated Primary Care and Behavioral Health Centralized Intake and Eligibility Determination-CIED

Networks

- **Quality Network**
  - Meeting regularly (every six weeks) since end of July
  - Completing QIPs using QI Toolkit, most agencies are on target or working with CQM support staff
- **Support Services Network**
  - Peers have been invited to this network starting in this FY
  - Met: 3/3/20, 9/3/20 (reviewed SDMs and discussed challenges to service delivery related to COVID-19)
- **Oral Health Network**
  - Met: 7/8/20 (reviewed oral health SDM)
  - Network had scheduled motivational interviewing training for April/May 2020, this was postponed due to COVID-19
- **Behavioral Health Network**
  - Met: 7/17/20 (reviewed mental health SDM)
- **Medical Network**
  - Met: 4/9/20, 9/3/20
- **DCM Network**
  - Met: 8/7/20 (reviewed DCM SDM)

Quality Improvement Projects (QIPs)

- **EMA QIP**
- **Quality Network Capacity Building-**
  - Quality Improvement Project (QIP) Toolkit has been distributed to the Network
  - This is a structured approach of guiding Broward Ryan White Part A Providers through their QI processes through the fiscal year.
- **Oral Health No-Show Project**
  - Data collection was completed in FY19
  - Final report on findings in progress

Agency QIPs	
QI Focus Area	**Number of Agencies Targeting Focus Area**
Telehealth	2
System Navigation and Linkage to Care	5
Retention in Care	1
Adherence	1
To Be Determined	2

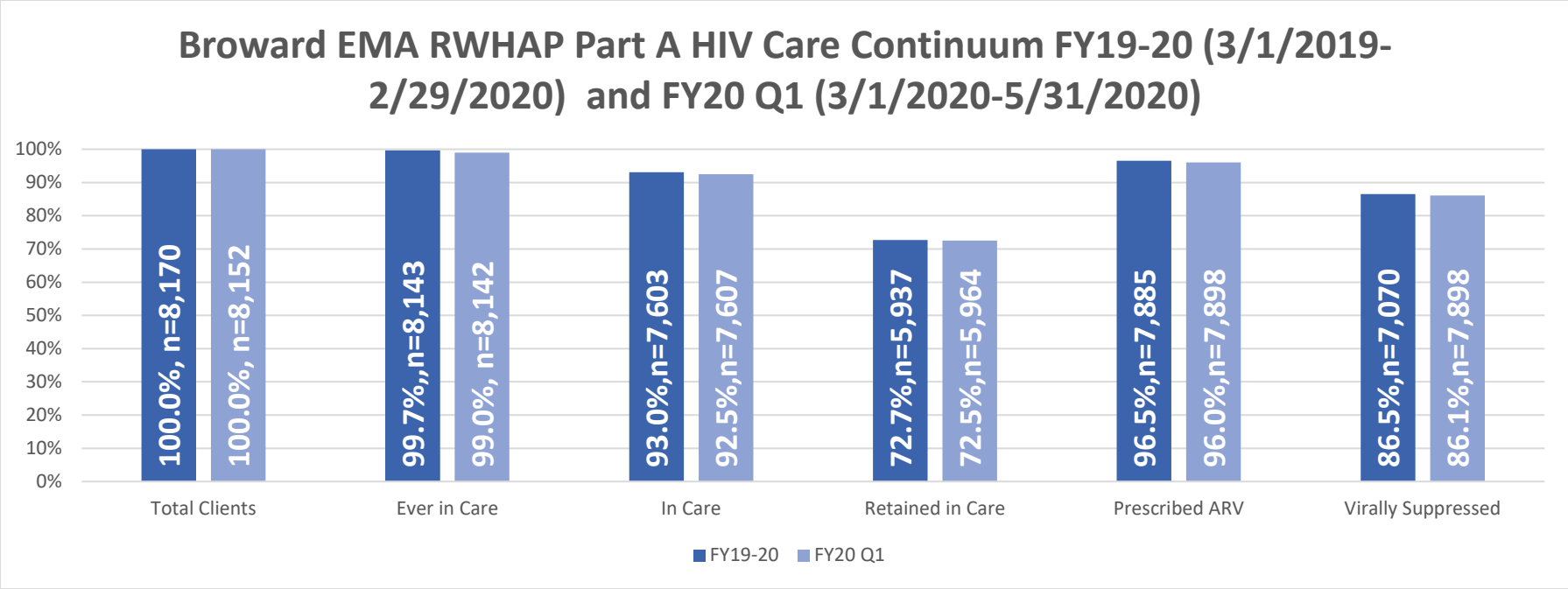
Trainings and Events

Provider Appreciation Week

- Our goal for this event is to provide encouragement, education, and resources to Part A providers during this challenging time.
- Each day will feature a short webinar with information, updates, and tips relevant for Broward Ryan White Part A providers. Webinar sessions will be recorded for future viewing.

2020 National Ryan White Conference on Care & Treatment

- CQM Team presented at the conference, over 20 people attended the session



Data Source: Provide Enterprise (PE) HIV Continuum of Care Report

Commentary: This chart shows the HIV Care Continuum for clients receiving services in the Ryan White Part A in FY2019-2020 (3/1/2019-2/29/2020) and for the first quarter (Q1) of FY2020 (3/1/2020- 5/31/2020). Minor decreases in all steps of the care continuum between FY2019-2020 and FY2020 Q1. This may be explained by differential service utilization due to COVID-19. Additionally, known challenges in obtaining viral suppression laboratory values may lead to a limitation in reporting accurate viral suppression rates.

Measure Definitions: (1) Total Clients: Clients with positive HIV serostatus and received at least one service from the selected service category(s) in the reporting period. (2**)** Ever in Care: Clients who ever had medical care documented. (3**)** In Care: Clients who had medical care within the reporting period. (4) Retention in Care: Clients who had two or more medical care services at least three months apart in the reporting period. (5) On ARV: Clients who have a documented prescription for ARV Therapy at any time during the reporting period as indicated in HIV treatment records. (6) Virally Suppressed: Clients with a most recent viral load at the of end of reporting period that is less than 200 copies/mL.

HIV Planning Council & Committee Demographics Report

It is the work of the Membership/Council Development Committee to ensure the HIV Planning Council is representative of the HIV epidemic in Broward County. One way that MCDC accomplishes this task is by reviewing the Council and Committees' demographics, identifying over and underrepresented populations.

HIV in Broward County

The following table shows HIV in Broward by Race/Ethnicity and by Gender. These data are provided by the Florida Department of Health.

Race	**Population**	**Percentage**
White	6,472	33%
Black	9,577	47%
Hispanic	3,957	18%
Other	359	2%
Total	20, 507	100%
Gender	**Population**	**Percentage**
Male	15,255	74%
Female	5,189	26%
Transgender	63	0%
Total	20, 507	100%

Totals updated as of September 2020

How This Information is Compared

The Council and each of its Committees are compared to the epidemic to determine where representation can be improved.

Key Terms

Epidemic – refers to the information in the table above. This is how HIV is distributed throughout Broward County.

Consumers – Council and Committee members who access Ryan White Part A services.

Unaffiliated Consumers – Council and Committee members who access Ryan White Part A services and have no relationship to an agency which provides these services. This means the consumer does not work for a provider agency or otherwise benefit financially from the agency's success.

Mandated Seats – HIVPC positions (seats) required by the Health Resources & Services Administration (HRSA).

Key Points for Reflectiveness through August 2020

HIV Planning Council (HIVPC): The Council remains below the HRSA mandated 33% unaffiliated consumer involvement. HIVPC's consumer membership decreased during the 2nd quarter due to a member's resignation. Overall membership is 21 and 1 new consumer member was provisionally approved by the HIVPC at its July meeting.

Community Empowerment Committee (CEC): CEC membership has increased in the 2nd quarter, but unaffiliated consumer membership has decreased from 44% to 40%. CEC's Policies & Procedures state that membership must be at least 51% consumers.

Membership/Council Development Committee (MCDC): MCDC has gained a member since the last meeting but remains under-representative of the epidemic.

Priority Setting & Resource Allocation (PSRA): The Committee's unaffiliated consumer membership has increased from 10% to 23%. Despite this increase, PSRA still has no Black, Hispanic, or female consumer representation.

Executive Committee: Due to a Chair's resignation from the HIVPC, there are no longer any unaffiliated consumer members serving in leadership positions. Improving this percentage is of particular focus in the 3rd Quarter.

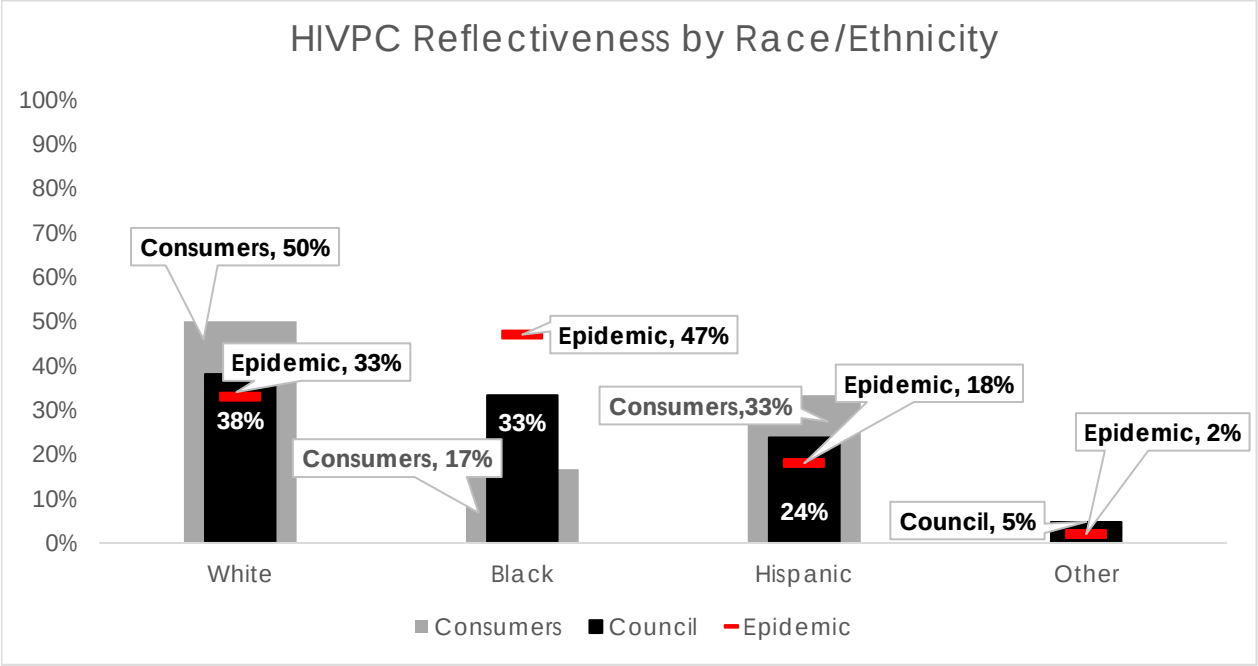
Quality Management Committee (QMC): QMC has gained 2 consumer members but remains unrepresentative of Black, Hispanic, and female consumers.

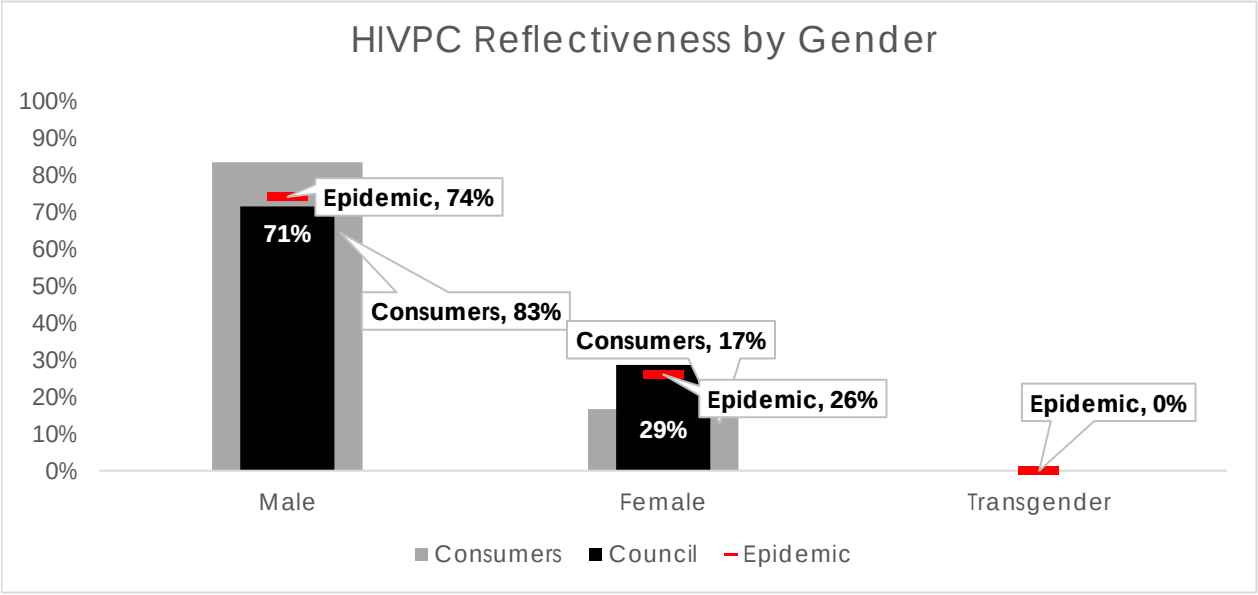
System of Care (SOC): SOC currently has 6 members, 2 of whom are consumers. The Committee will begin meeting in September of 2020 and will continue efforts to increase its membership.

HANDOUT G

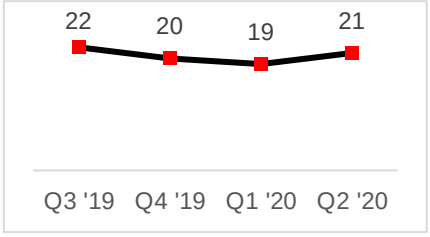
HIV Planning Council Reflectiveness Report

Current Through August 2020

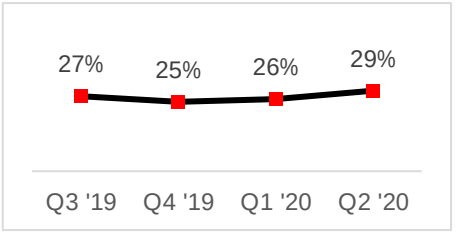




HIVPC Membership over 1 CY



Unaffiliated Consumer Membership over 1 CY



Gender	Epidemic		Council		% Difference	Consumers		% Difference
Male	15,255	74%	15	71%	-3%	5	83%	9%
Female	5,189	25%	6	29%	3%	1	17%	-9%
Transgender	63	0%	0	0%	0%	0	0%	0%
Race	**Epidemic**		**Council**		**% Difference**	**Consumers**		**% Difference**
Hispanic	3,957	19%	5	24%	5%	2	33%	14%
Black	9,577	47%	7	33%	-13%	1	17%	-30%
White	6,472	32%	8	38%	7%	3	50%	18%
Other	359	2%	1	5%	3%	0	0%	3%
Age	**Epidemic**		**Council**		**% Difference**	**Consumers**		**% Difference**
0-12	15	0.1%	0	0%	0%	0	0%	0%
13-19	70	0.3%	0	0%	0%	0	0%	0%
20-29	1,277	6.2%	0	0%	-6%	0	0%	-6%
30-39	3,068	15.0%	2	10%	-5%	0	0%	-15%
40-49	4,062	19.8%	3	14%	-6%	0	0%	-20%
50-59	6,828	33.3%	7	33%	0%	3	50%	17%
60+	5,187	25.3%	9	43%	18%	4	67%	41%
Total	20,507	99.3%	21	100%		6	100%	

No more than 3 members employed by one governmental agency or provider shall serve on the HIVPC at one time, and no more than 40% of HIVPC members shall be Part A-funded providers.

% Part A-Funded Providers	*33%*

Current Members	21
Minimum (Per County Ordinance)	20
Maximum (Per County Ordinance)	35
% Unaffiliated Consumers	29%

Vacant Seats
1. Grantees of Other Federal HIV Programs - VA
2. Federally Recognized Indian Tribe Members
3. State Medicaid
4. Local Public Health Agency
5. Health Planning
6. Alternates (3)
7. Co-infected with Hepatitis B or C
8. Substance Abuse Provider

#GetInvolved:

Engaging Youth/Young Adults in Planning Council/Planning Body Activities

Venton Hill-Jones (Southern Black Policy and Advocacy Network; Member, Ryan White Planning Council of the Dallas Area)
Eddie Wiley (Planning CHATT)
Michelle Dawson (Planning CHATT)

PLANNING CHATT
Community HIV/AIDS Technical Assistance & Training

JSI

1

Learning objectives

- Understand value of a multigenerational PC/PB in meeting the RWHAP goals of representativeness
- Learn strategies to engage and retain youth and young adults in planning council activities
- Identify changes to planning council/planning body operations to increase youth and young adult participation
- Understand youth and young adults' perspective on involvement in PC/PB

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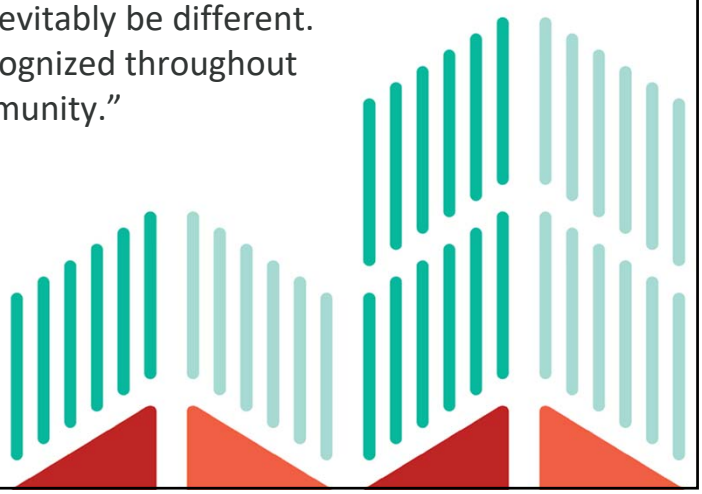
2

"It's important to have youth/young adult involvement because [our] perspectives will inevitably be different. So we must be embraced and recognized throughout the planning bodies and the community."

Courtney
Dallas, TX



3

Value of a multigenerational PC/PB in meeting the RWHAP goals of representativeness

4

Core Tasks of Planning Councils and Planning Bodies

- Determine service needs
- Establish "priorities for the allocation of funds"
- Provide guidance to the recipient on "how best to meet these priorities"
- Help ensure coordination of RWHAP and other services, including prevention

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5

Value of a Multigenerational PC/PB

- Reflectiveness of the epidemic - need to voice and meet the needs of everyone in our community
  - People who are aging with HIV
  - People who are young/newly diagnosed
  - Transgender people and gender non-conforming people
  - Diversity within subpopulations
- Provide a voice for the populations they represent
- Community memory
- Sustainability of the PC/PB
- Response to the epidemic has changed, and Y/YA can help to ensure the uptake of new interventions

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6

Strategies for Multi-Generational Harmony

- Establish respect
- Be flexible and accommodating
- Avoid stereotyping
- Learn from one another
- Tailor your communication style
- Don't overlook similarities—find "intergenerational common ground"

*Strategies adapted from MindTools

7

Establish Respect

- Be mindful of ageism
- Monitor how to support environment of shared leadership

Examples of problematic actions:

- Using how long you have been involved in the HIV world to diminish the value of another
- Young people telling older people that they should step aside
- Older people telling younger people that young people "don't understand..."

8

Learn from One Another

- Revise mentorship from leadership development based on age (older to younger), to mentorship based on experience or skills in a role.
- Consider terms such as “Accountability Partner” rather than mentor

9

“Having us involved in planning bodies brings a fresh eye to the issues that really need to be addressed. Especially when those issues affect us most often. We also have a connection to our peers and can have a larger conversation about our needs (and wants) for our generation.”

Durrell
Jackson, MS

10

Strategies to engage and retain youth and young adults in planning council activities

11

Intentionality

Make it an intentional priority to have meaningful involvement of youth/YA—involvement of youth/young adults needs to be an intrinsic value of the PC

- Change driven by leadership invested in the outcome
- Set goals
- Track progress to sustain intentional efforts over time

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12

Review Your Current Recruitment Activities

- Who develops your materials?
- What do the materials look like?
- Where do you advertise?
- What language do you use?
- Where do you recruit?
- When do you recruit?
- Who does the outreach and recruitment?

13

What Can We Change? Recruitment Strategies

- Make changes to recruitment efforts
- Enable and empower youth and young adults who are currently involved to guide recruitment efforts
- Consider:
  - What language should be used?
    - Who are the different groups of young people? How do you tailor to the groups?
  - What imagery should be used?
  - Where should we recruit?

14

Where Do I Find Young People?

- Youth-oriented service providers
- Drop-in spots
- Local colleges/universities
- Hang out spots
- With other young people!

15

How Do I Talk to Young People?

- Language (e.g. not using “consumer”)
- Frame PC/PB involvement in the context of the current milieu
  - Frame HIV as a part of health/wellness
  - Link involvement in community HIV/AIDS planning to social justice and community activism

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Challenges of Recruitment

- Knowing "how to find" and "how to talk to" youth when you have very few on your PC/PB
- Youth/Young Adult's stage of life affects their perceived availability to make a long-term commitment
- Youth/Young Adults perceive their experience as intellectual property, and want to be compensated

17

"I think it's important that other people see us as more than 'kids'. We have a voice that matters. We can make a contribution to the conversation. It's harder for some than it is for others, but we can help nurture that voice through our planning bodies and give the youth a platform."

Mitchell

New Orleans, LA

18

Recruitment is only as successful as engagement and retention!

19

Strategies for Success

- Find and engage a Y/YA Champion - elevate this person so that they can make a long-term impact on PC/PB
- Use language that frames HIV in the context of health and wellness
- Meeting times
  - Allow for flexibility in modality of attendance
  - Limit extra meetings
- Avoid tokenization - a person should be at the table because of their leadership potential, not just because they are young

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20

Strategies for Success

- Employ/engage young people as interns and staff
  - Pay whenever possible
  - Provide volunteer/community service hours
  - Make an announcement of job openings within PC/PB
- Incentivize engagement with PC/PB with something demonstrable
  - Supported attendance at conference (e.g. USCHA or state conference on HIV)
  - Documentary
  - Other type of completed project

21

Strategies for Success

- Offer intentional, specialized training before important PC/PB events describing:
  - What the activity is
  - Context for the activity
  - Process steps involved
- Formal/Informal mentorship by more *experienced* members, not necessarily older members
  - Of PC operations
  - Of working in a public health policy space
  - Peer-to-peer

22

Models of Youth Engagement

- General, representative membership in PC & PC leadership
- Youth Advisory Committee/Youth Caucus (subcommittee, as needed)
- "At-large" membership prior to full membership to build experience with PC/PB operations prior to making commitment

23

All Youth Leadership is Not the Same

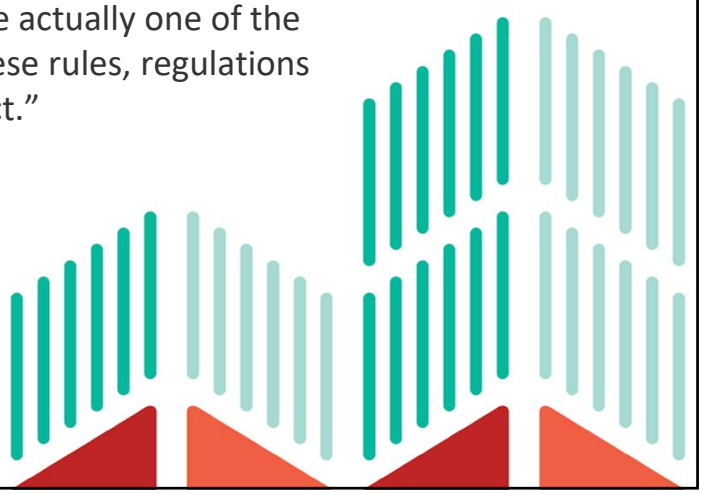
There is a space for everyone in the PC/PB - need to find and nurture the appropriate space for each interested person

- Could be a consumer member where you represent your communities
- Could be a burgeoning leader whose interest in leadership and public health should be nurtured and developed
- Could be an established leader who can invent and run with new initiatives

24

"We bring the youth perspective. We can be innovative to affect change. Our opinions are actually one of the most important because all of these rules, regulations and/or advancements really affect."

Avery
Nashville, TN



25

NOW IT'S YOUR TURN (please respond in the chat)

What is something the PC accomplished to make a positive impact on people living with HIV?

PLANNING CHATT
Community HIV/AIDS Technical Assistance & Training

JSI

Thank you!

eddie_wiley@jsi.com
msamplin@jsi.com

26

HANDOUT I

To the members of the HIVPC, Broward County HIV Health Services Planning Council:

February 27th, 2020

Requel Lopes, Chair:

This is a formal request for all 3 planning bodies to join in solidarity for the "Ending the Epidemic Initiative" (EtHE) and participate in a much needed summit on the state of affairs for HIV in Broward County. We're asking for you to vote for your support of the attached letter to commit to work together for the EtHE efforts.

Attached you will find the Letter sent to the DOH Administrator 2/13/20 as voted by the Consortia (SFAN), and ratified by the Prevention Council (BCHPPC) regarding the existing situation, as we are consistently in the top 3 in new infections nationwide. We desperately need to improve what, how, when, & for whom all services are provided in Broward County. We have growing support from the community at large, and over 50 signatures from various community members in support of this effort.

5 essential actions we need to agree to do so we can break the cycle:

1) Create an "annual State of HIV in Broward County Summit"
2) Reconnect the (former) "Joint committees" for a more comprehensive approach to their topics (add BCHPPC & or HOPWA committees where relevant) understanding the DOH must contribute their fair share of the costs of this required administrative function
3) Support one "Comprehensive plan" – including all HIV funds for Broward County
    a. Update from the Hospital Districts on their HIV strategy
4) Reconstitute the Integrated committee with a new & improved process
5) Join in creating "HIV Score Cards" for all 3 planning bodies: Survey input on Grantees, Services offered, and a county wide Client satisfaction survey / process
6) Create a "Getting to Zero campaign" that will aid in our unifying efforts and showcase broad support from the community to review everything funded for HIV and how well it is working in our County.

We hope you will join us in pushing for change, breaking down the status quo, and getting more meaningful engagement of the community by more inclusive decision making & more transparency. Together we can achieve success!

Sincerely,

Joey Wynn,

Immediate Past Chairman, SFAN and Current Co-Chair, FHAAN

ORIGINAL

HANDOUT I

Paula Thaqi, Administrator
Florida Department of Health in Broward County
2421 SW 6th Ave, Fort Lauderdale, FL 33315

February 13th, 2020

Re: Announcement CDC-RFA-PS20-2010: Integrated HIV Programs for Health Departments to Support EHE.

The purpose of PS20-2010 is to implement comprehensive HIV programs that complement existing programs, designed to support ending the HIV epidemic in America by leveraging powerful data, tools, and resources to reduce new HIV infections by 75% in 5 years. CDC strongly encourages applicants to propose **disruptively innovative activities** unique to their jurisdiction's local context.

It should be highlighted that the RFA states that community engagement processes involve the collaboration of key stakeholders and communities who collaboratively identify strategies for increased coordination of HIV programs throughout the state and local health jurisdictions. ***Strategy C5***: Facilitate the development of partnerships with other community HIV clinical providers and health department and community-based organizations providing HIV prevention services and collaborating in the implementation of the EHE.

The recipient must **devise a process and allocate resources**, to assist the jurisdictions with the use of epidemiologic and social determinants data to identify communities within their jurisdictions disproportionately affected by HIV and related diseases and conditions.

Strategy 1: Diagnose all people with HIV as early as possible

Strategy 1A: Expand or implement routine opt-out HIV screening in healthcare and other institutional settings located in high prevalence communities

Strategy 1B: Develop locally tailored HIV testing programs in non-healthcare settings

Strategy 1C: Increase at least yearly re-screening of persons at elevated risk for HIV per CDC testing guidelines, in healthcare and non-healthcare settings

Strategy 2: Treat people with HIV rapidly and effectively to reach viral suppression

Strategy 3: Prevent new transmission by using proven interventions, including PrEP & syringe services programs (SSPs)

Strategy 3A: Accelerate efforts to increase PrEP use, particularly for populations with the highest rates of new HIV diagnoses and low PrEP use among those with indications for PrEP.

- ✓ **Fund more than one external provider in this county, in addition to the DOH providers.**

Strategy 3B: Increase availability, & access to and quality of comprehensive Syringe Services Programs (SSPs)

Strategy 4: Respond quickly to potential HIV outbreaks to get prevention and treatment services to people in need.

Strategy 4A: Develop partnerships, processes, data systems, and policies to facilitate robust, real-time cluster detection and response

- ✓ **Create an education intervention for the community as well as the service delivery system's staff to reduce fear & opposition to molecular surveillance.**

Strategy 4C: Identify and address gaps in programs and services revealed by cluster detection and response.

COPY

We the community members of the Broward County Jurisdiction strongly urge, and expect the local Florida Department of Health in Broward County to rapidly deploy the following solutions to improve the impact of our EHE efforts ongoing and begin to effectively manage the epidemic locally:

- **Establish a baseline to measure from for the EHE state of the epidemic in Broward County:**
  - Initiate a countywide "**state of the epidemic all day Summit**" with community partners, key stakeholders, all 3 HIV planning bodies (then annually) to foster improved networking, transparency based on progress with metrics & regularly scheduled quarterly update calls.
  - Select key metrics to see if we are on track, outcomes are in alignment with the EHE plan, the integrated plan, and local Ryan White applications to Federal Grantees.
- **Restructure the Broward County HIV Prevention Planning Council (BCHPPC) to reflect the severity of the epidemic:**
  - Dissolve & restructure the group into an HIV Prevention Action Council that meets monthly (as it was previously structured 10 years ago) with less complex bylaws, policies & procedures to allow for community participation, flexibility and a less intimidating environment; this ensures members of communities aren't discouraged from participating.
- **Improve prevention meeting accessibility**:
  - Move the monthly meetings away from governmental institutions, with an emphasis on being near the heart of the epidemic in Zip code 33311.
  - Provide refreshments, microphones so all can be heard & additional materials for community members that attend.
- **Remove local Dept. of Health Conflict of Interest at Prevention meeting:**
  - Have all DOH voting representation removed, leaving only the DOH Co Chair. The perceived and actual conflict of interest we have experienced over the past 10 years is hindering progress and hampering community involvement by stifling open thought & community opportunity to participate. DOH totally dominating the meeting & pressuring people that ask questions has made many people, and agencies, stop attending.
- **Improve attendance at the Prevention planning body**:
  - Allow the community to set some of the agenda, with room for DOH required tasks afterward, not the entire meeting; fostering meaningful engagement.
  - Make the length reasonable, 4 hours is not conducive for community participation. Many cannot take a half day off for a meeting. Meet monthly, for 2 hours; this is best practice as SFAN has enjoyed tremendous turn out with this model for 3 decades.
- **Improve the ability of the community to participate in decision making:**
  - Make the meeting a conversation, not didactic.
  - Provide time for response after each topic, record how each person votes.
  - Provide a list of action items, to be first on next meeting to measure progress
- **Improve Transparency & Meaningful engagement:**
  - Require open, transparent, and readily accessible meeting dates, locations & agenda schedules. Have them **easily** available to the public, through monthly email updates, share with SFAN, Part A, School Board & other community based list serves to remove the cloak of uncertainty about what is going on. Simply embedding information on difficult to navigate websites is not a partnership; local staff should be more proactive in providing information the community members & groups are asking for.

- **Improve the community's ability to engage in meaningful conversation & decision making (MIPA) & provide Leadership in the innovative change required for a successful response:**
  - Delegate the required community advisory board function to the already existing advisory board, the South Florida AIDS Network – Broward, BCHD's legally recognized local advisory board; SFAN has for the past 30 years proven vast community representation, attention & discussion regarding all aspects of the HIV service delivery system, and at one point, housed the prevention committee before the change to the current BCHPPC model. The group has the knowledge, skills, expertise & ability to add these duties immediately.
  - Have standing meeting reports emailed to the members and interested parties a week **before** meetings so the members may come prepared, with questions already formalized, and proposed solutions based on sound facts.
- **Improve Coordination & Collaboration with Key Stakeholders:**
  - Provide monthly utilization reports so the community can see how the funds are being spent (Utilize Patient Care Budget models used by Part A & Part B planning bodies)
  - Require attendance from DOH at other planning bodies, provide a written report & offer to allow them to reciprocate.
  - Require sign off from all planning bodies on quarterly HAPC reports to the state on activities & evaluation of progress to foster & confirm communication, coordination, accuracy & accountability.
- **Remove bottle neck in service delivery system**:
  - Procure functions requiring community contact, as the priority populations disproportionately affected by HIV needing to be reached the most have historical barriers with the local DOH; the agency must fund medium & smaller CBOs with critical historical experience working with these communities; they are essential to do the job effectively.
  - Use the Purchase order process rather than the restrictive contracting process to allow for smaller agencies to do what they do best and promote active community-level engagement.
- **Institute Community feedback for the administrative mechanism:** for CDC and RW Part B Programs to ensure accountability – The local HAPC rarely appears at the advisory body for Part B. The BCHPPC sees the HAPC, but only occasionally, but the Administrator never attends either group. We need to hear from them, their intent, and provide feedback to course correct the plan.
  - Require an annual presentation & update from the Administrator to both groups.
  - Require monthly meeting attendance from the HAPC at the advisory groups.
  - Require semiannual written feedback to the HIV Section in Tallahassee with community satisfaction report cards of the HAPC Role, and the overall administration of the Grants (CDC & RW). Part A's "Evaluation of the Administrative entity" is a great template to use.
- **Reset the relationship with the local Consortia & improve cooperation with community:**
  - Provide information without having to have formal votes to get it.
  - Rejoin committees (split apart 6 years ago) to ensure productivity & increased coordination for optimal planning centered in community engagement.
  - Refrain from comments such as "Why do we even need SFAN?" What is the necessity of the local consortia? Stop reporting "it is difficult to reach the community" when it meets monthly, and is trying to provide input. Over 75 members, 45 agencies & decades of experience reside in this group. They should be your go to source for engagement.

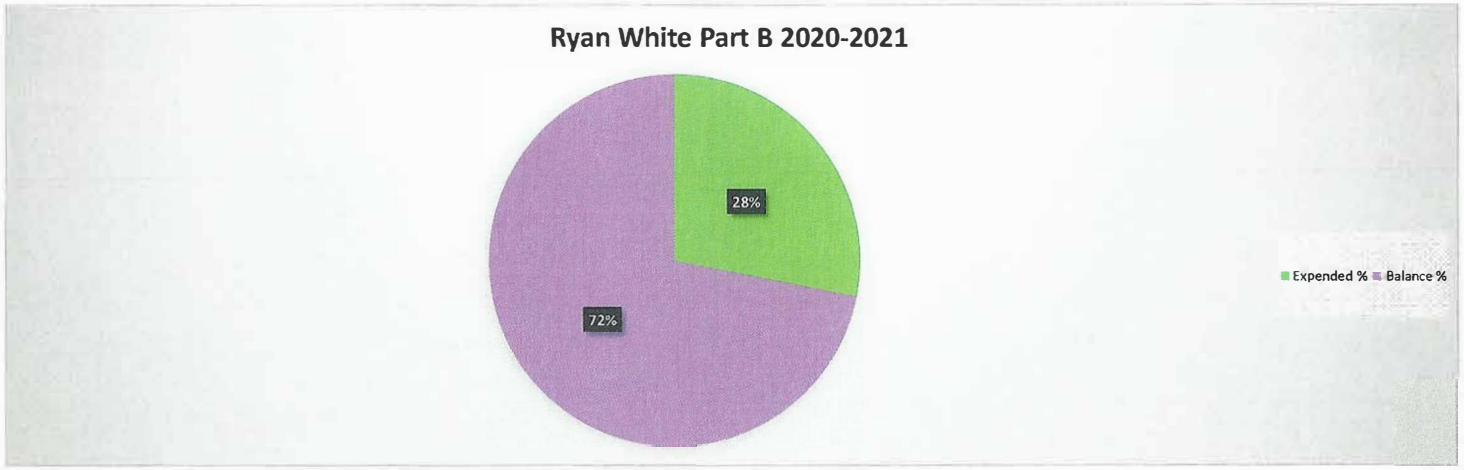
HANDOUT J

Ryan White Part B
PTC19: April 1, 2020 to March 31, 2021

Expenditures for August 2020

Service Category	Allocated	Expended August 2020	Expended this Year	Clients Served	Clients Served YTD	Expended %	Balance %	Balance
Administrative Services	$ 75,535	$ 7,404	$ 35,708			47%	53%	$ 39,826.85
Health Insurance Premium/Cost Sharing	$ 167,750	$ 2,813	$ 24,997	5		15%	85%	$ 142,753.26
Home & Community Based Health	$ 30,000	$ 2,015	$ 8,809	4		29%	71%	$ 21,190.85
Medical Nutritional Therapy	$ 10,000	$ 1,950	$ 7,621	14		76%	24%	$ 2,379.13
Emergency Financial Assistance	$ 150,654	$ 5,634	$ 68,933	26		46%	54%	$ 81,721.12
Home Delivered Meals	$ 30,000	$ 693	$ 3,615	2		12%	88%	$ 26,384.75
Medical Transportation	$ 135,476	$ 509	$ 18,233	1		13%	87%	$ 117,242.64
Non-Medical Case Management	$ 321,770	$ 44,737	$ 108,389	859		34%	66%	$ 213,381.45
Residential Substance Abuse **	$ 166,500	$ 10,112	$ 27,543	5		17%	83%	$ 138,956.95
Clinical Quality Management	$ 58,096	$ 11,282	$ 22,796			39%	61%	$ 35,300.36
Planning and Evaluation	$ 16,148	$ -	$ -			0%	100%	$ 16,148.00
TOTALS	$ 1,161,929	$ 87,148	$ 326,644	916	0	28%	72%	$ 835,285.36

**Clients were served; however invoicing issues delayed posting in a timely manner.



Serena R. Cook 954-412-7086

ADAP AUGUST 2020

HANDOUT J

Total Enrolled	5,237
Total Virally Suppressed	4,767
Percentage of Virally Suppressed (91.03%)	92%

ADAP Enrollments and Re-enrollments Processe	882

Enrolled in Mail Order Delivery	1,340
Total Enrolled in Direct Dispense	2,608

Total Enrolled in Online Recertification	1,830

No Show Report	19.14%

HANDOUT J

PRINTED ON 09/01/2020

FLORIDA ADAP SUPPRESSED VIRAL LOAD BY COUNTY

FOR From 8/1/2020 Through 8/31/2020

State Goal: 92%

County Name	Clients with Suppressed VL	Total Clients	Percentage
BROWARD	4,767	5,237	91.03%
FOR SELECTED COUNTIES	4,767	5,237	91.03%

Greater or equal to 92%

Greater or equal to 85% but less than 92%

Less than 85%

HANDOUT J

ENROLLMENTS AND RE-ENROLLMENTS BY COUNTY AND AREA

2019-08-01 To 2019-08-31

Area/Selected County		Initial Enrollments	Re-enrollments
Area 10	Broward	67	815
Totals for Area 10		67	815
Totals for Selected Counties		**67**	**815**